NAME: _____

SSN: _____

CLAIMANT - SEIZURE QUESTIONNAIRE

1. How long have you been having seizures? _____.
2. Date of last seizures? _____.
3. How long do they last? _____.
4. How many seizures have you had in each of the last 6 months?

	Month	Number of seizures
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

5. Do the seizures happen during daytime? _____. At night while sleeping? _____.
6. Describe what happens to you as far as you can remember, just before, during and after a seizure. _____

_____

_____

_____

_____

7. Do you take medicine regularly as instructed? _____. What is the name of your medicine(s)? _____
8. How often a day do you take each type of medication? _____

_____

9. Name and address of the doctor, hospital or clinic that gave you this prescription? _____

_____

10. How often do you get medicine refilled? _____. Give name and telephone number of drug store and prescription number of your medicine.

_____

_____

11. Have you seen a doctor recently for your seizures? _____. If yes, who and when? _____

12. Has your doctor advised you not to drink alcohol? _____

13. Do you drink alcohol? _____. If yes: How often? _____

14. Do you get seizures when you drink or soon after you drink? _____

15. Do you also get seizures when you are not drinking? _____

16. Has a friend or relative, doctor or other person seen you while you were having a seizure? ( ) Yes ( ) No. If yes, do you authorize this Agency to contact this person to obtain information about your seizure condition. ( ) Yes ( ) No. Please give their name, address, telephone number, and relationship to you. _____

_____

_____

USE THIS SPACE TO ADD ANY ADDITIONAL INFORMATION ABOUT YOUR SEIZURES.

YOUR SIGNATURE _____

TELEPHONE NUMBER _____ DATE _____